FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025130

Facility Name: CARRIER MILLS NURSING HOME

Address: 6789 ROUTE 45, P. O. BOX 68 (Number) CARRIER MILLS (City) 62917 (Zip Code)

County: SALINE

Telephone Number: (618) 994-2323 **Fax #** (618) 994-4082

IDPA ID Number: 37-1077294001

Date of Initial License for Current Owners: JAN. 1, 1979

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name WILLIAM H. MOORMAN **Telephone Number:** (618) 993-2647

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) WILLIAM H. MOORMAN, CPA, PARTNER
(Firm Name & Address) GRAY HUNTER STENN LLP,PO BOX 1728 MARIO
(Telephone) (618) 993-2647 Fax (618) 993-3981

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

ON, IL

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,505	396	2,569	4,470	8
9	SNF/PED					9
10	ICF	21,367	7,785	24	29,176	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,872	8,181	2,593	33,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 92.86%

D. How many bed-hold days during this year were paid by Public Aid? 232 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/68

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/29/78 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2191

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	99,366	16,998	3,838	120,202		120,202	0	120,202			1
2	Food Purchase		118,187		118,187		118,187	0	118,187			2
3	Housekeeping	139,438	14,005		153,443		153,443	0	153,443			3
4	Laundry	37,634	16,137		53,771		53,771	48	53,819			4
5	Heat and Other Utilities			67,655	67,655		67,655	364	68,019			5
6	Maintenance	27,739		39,372	67,111		67,111	806	67,917			6
7	Other (specify): SALES TAX			3,101	3,101		3,101	(3,101)				7
8	**TOTAL General Services**	304,177	165,327	113,966	583,470		583,470	(1,883)	581,587			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300	0	3,300			9
10	Nursing and Medical Records	743,994	134,373	1,305	879,672		879,672	0	879,672			10
10a	Therapy	47,650		32,792	80,442		80,442	0	80,442			10a
11	Activities	25,423	561	1,080	27,064		27,064	0	27,064			11
12	Social Services	27,914		1,080	28,994		28,994	0	28,994			12
13	Nurse Aide Training	2,496		1,600	4,096		4,096	0	4,096			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	847,477	134,934	41,157	1,023,568		1,023,568		1,023,568			16
	C. General Administration											
17	Administrative	18,000			18,000		18,000	122,458	140,458			17
18	Directors Fees							0				18
19	Professional Services			228,995	228,995		228,995	(208,416)	20,579			19
20	Dues, Fees, Subscriptions & Promotions			13,032	13,032		13,032	(6,119)	6,913			20
21	Clerical & General Office Expense	56,865	20,184	10,289	87,338		87,338	12,498	99,836			21
22	Employee Benefits & Payroll Taxes			197,947	197,947		197,947	4,466	202,413			22
23	Inservice Training & Education			1,836	1,836		1,836	0	1,836			23
24	Travel and Seminar			1,058	1,058		1,058	0	1,058			24
25	Other Admin. Staff Transportation			16,795	16,795		16,795	2,048	18,843			25
26	Insurance-Prop.Liab.Malpractice							203	203			26
27	Other (specify): IL REPLACE TAX			3,707	3,707		3,707	(3,707)				27
28	**TOTAL General Administration**	74,865	20,184	473,659	568,708		568,708	(76,569)	492,139			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,226,519	320,445	628,782	2,175,746		2,175,746	(78,452)	2,097,294			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,612	14,612		14,612	90,389	105,001			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							133,158	133,158			32
33	Real Estate Taxes			50,218	50,218		50,218	403	50,621			33
34	Rent-Facility & Grounds			220,800	220,800		220,800	(220,800)				34
35	Rent-Equipment & Vehicles			4,238	4,238		4,238	0	4,238			35
36	Other (specify):*							0				36
37	TOTAL Ownership			289,868	289,868		289,868	3,150	293,018			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			54,352	54,352		54,352	0	54,352			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			54,352	54,352		54,352		54,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,226,519	320,445	973,002	2,519,966	0	2,519,966	(75,302)	2,444,664			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	35,523	V-30		9
10	Interest and Other Investment Income	(504)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,101)	V-07		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(617)	V-20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,304)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,707)	V-27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,445)	V-20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 21,845		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(97,147)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (97,147)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (75,302)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 0		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name CARBER MILLS NURSING HOME

ID# 0025120

Report Period Beginning: 01/01/89

Ending: 12/31/89

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	0
9	**Non-Straightline Depreciation**	35,523	V-30	**Line 9**	0
10	**Interest and Other Investment Income**	(504)	V-32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(3,101)	V-07	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	0
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	(617)	V-20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	0
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(1,304)	V-20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	(3,707)	V-27	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	(4,445)	V-20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	0
30	**Donated Goods**	0	0	**Line 29**	0
31	**Amortization Expense**	0	0	**Line 30**	0
32				**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(62,878)	0	0	0	0	0	0	0	0	0	(62,878)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(62,878)	0	0	0	0	0	0	0	0	0	(62,878)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(62,878)	0	0	0	0	0	0	0	0	0	(62,878)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	52,869	0	0	0	0	0	0	0	0	0	52,869	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	133,662	0	0	0	0	0	0	0	0	0	133,662	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(220,800)	0	0	0	0	0	0	0	0	0	(220,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(34,269)	0	0	0	0	0	0	0	0	0	(34,269)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(97,147)	0	0	0	0	0	0	0	0	0	(97,147)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe CARRIER MILLS NURSING HOMI # 0025120 Report Period Beginning 01/01/00 Ending 12/31/00

Show Pgs 6A thru

Show Pgs 6E thru 6I

Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER D. HERRIN	62%	SALINE CARE CENTER	HARRISBURG, IL	CARRIER MILLS		
GROVER S. SLOAN	17%	SEYERN INTERMEDIATE CARE	BENTON, IL	NURSING HOME		
ALICE STALLINGS	11%			LAND TRUST	CARRIER MILLS, IL	LAND TRUST
PENNY SISK	10%			RDK MGMT, INC.	HARRISBURG, IL	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	Sum_6
1	V	19 PROFESSIONAL SERVICES	$ 289,307	RDK MANAGEMENT, INC (SEE ATTACHED SCHEDULE		$ 140,429	$ (62,878)	-62878
2	V	20 DUPLICATION		CARRIER MILLS NURSING HOME LAND TRUS		52,307	52,869	52869
3	V	22 INTEREST		CARRIER MILLS NURSING HOME LAND TRUS		133,102	133,102	133102
4	V	23 LOAN FEE EXPENSE		CARRIER MILLS NURSING HOME LAND TRUS		560	560	560
5	V	24 RENT	220,800	CARRIER MILLS NURSING HOME LAND TRUS			(220,800)	-220800
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 430,107			$ 332,960	$ * (97,147)	14

* Total must agree with the amount recorded on line 24 of Schedule V SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROGER D. HERRIN	STOCKHOLDER	MANAGER	62.00%	279,042	20	29.00	MGMT FEI	$ 122,458	17-7	1
2	GROVER S. SLOAN	STOCKHOLDER	DOCTOR	17.00%						-	2
3	ALICE STALLINGS	STOCKHOLDER	ADMINISTRAT	11.00%	39,502	VARIOUS	VARIOUS	SALARY	18,000	17-1	3
4	"	"	"			VARIOUS	VARIOUS	SALARY	153	21-7	4
5	PENNY SISK	STOCKHOLDER	BOOKKEEPER	10.00%	39,381	VARIOUS	VARIOUS	SALARY	7,500	21-1	5
6	"	"	"			VARIOUS	VARIOUS	SALARY	8,286	21-7	6
7											7
8											8
9	*SEE ATTACHED SCHEDULE										9
10											10
11											11
12											12
13								TOTAL	$ 156,397		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

(1) FROM ALLOCATION OF MANAGEMENT EXPENSES

the name(s)
PORTS.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRSTAR BANK N.A.		X	CONSTRUCTION	$14,451.00	4/23/1993	$ 1,800,000	$ 1,477,389	04/23/2003	9.00%	$ 133,102	1
2	(PADUCAH, KY)											2
3												3
4												4
5												5
	Working Capital											
6	DR. ROGER HERRIN	X		WORKING CAPITAL	SINGLE PAY	6/08/1989	2,895	2,895	DEMAND	10.00%		6
7												7
8												8
9	TOTAL Facility Related				$14,451.00		$ 1,802,895	$ 1,480,284			$ 133,102	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,802,895	$ 1,480,284			$ 133,102	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

NOTE: THE NOTE HELD WITH FIRSTAR BANK N.A. OF PADUCAH IS IN THE NAME (1) VARIABLE INTEREST RATE LOAN 9% AS OF 12/31/00.
CARRIER MILLS NURSING HOME LAND TRUST, WHICH IS A RELATED PARTY TO
CARRIER MILLS NURSING HOME, INC.

Facility Name & ID Numbe CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	42,789	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	48,078	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,289	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,332	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	50,621	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	26,569	8
	1996	33,094	9
	1997	45,714	10
	1998	45,938	11
	1999	48,078	12

ACCRUAL BASED ON TAXES PAID IN 2000 FOR 1999.

(1) INCLUDES $ 403 FROM ALLOCATION OF MANAGEMENT EXPENSES.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Numb CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,462 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SEE ATTACHED SCHEDUL	406,342		$ 27,915	1
2					2
3	TOTALS	406,342		$ 27,915	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

(1) INCLUDES ALLOCATION OF HOME OFFICE ASSETS.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1979	1968	$ 316,676	$ 6,537	25	$ 12,667	$ 6,130	$ 285,784	4
5	57		1992	1992	1,200,956	38,564	25	48,038	9,474	385,745	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			1979	4,155		15			4,155	9
10	REDECORATING			1980	8,104		7			8,104	10
11	LANDSCAPING			1980	1,159		7			1,159	11
12	TILE			1983	225		5			225	12
13	LANDSCAPING			1983	220		5			220	13
14	IMPROVEMENTS			1985	450	18	20	23	5	360	14
15	IMPROVEMENTS - AIR CONDITIONER			1985	17,045	313	15	393	80	17,045	15
16	IMPROVEMENTS			1985	3,110		10			3,110	16
17	IMPROVEMENTS - AC COMPRESSOR/WATER HEATER			1986	1,772	92	15	118	26	1,718	17
18	IMPROVEMENTS - FLOORING/LANDSCAPING			1987	3,112	108	15	207	99	2,864	18
19	IMPROVEMENTS - REDECORATING			1988	1,153		10			1,153	19
20	CARPETS			1989	180		5			180	20
21	IMPROVEMENTS - WASHERS/DRYERS/BATHTUB			1993	32,837	1,465	10	3,284	1,819	26,272	21
22	IMPROVEMENTS - ALLOCATED ASSETS (1)			1993	33,225	862	30	1,108	246	7,234	22
23	IMPROVEMENTS - ROOF			1994	16,000	400	30	533	133	3,731	23
24	IMPROVEMENTS - ALLOCATED ASSETS (1)			1994	1,436	50	30	48	(2)	276	24
25	IMPROVEMENTS - ALLOCATED ASSETS (1)			1996	53	4	30	2	(2)	9	25
26	IMPROVEMENTS - TILE WORK			1997	6,682	836	30	223	(613)	892	26
27	IMPROVEMENTS - STORAGE BUILDING			1998	1,000	26	39	26		68	27
28	IMPROVEMENTS - ALLOCATED ASSETS (1)			1998	242	6	30	8	2	24	28
29	IMPROVEMENTS - ALLOCATED ASSETS (1)			2000	5,338	183	30	178	(5)	178	29
30											30
31											31
32											32
33											33
34	(1) ALLOCATION OF HOME OFFICE ASSETS - SEE SCHEDULE										34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,655,130	$ 49,464		$ 66,856	$ 17,392	$ 750,506	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 353,976	$ 16,678	$ 35,398	$ 18,720	10	$ 302,588	37
38	Current Year Purchases	27,475	4,184	2,747	(1,437)	10	2,747	38
39	Fully Depreciated Assets	110,250					110,250	39
40								40
41	TOTALS	$ 491,701	$ 20,862	$ 38,145	$ 17,283		$ 415,585	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	TRAVEL	1995 MERCEDES 500 SL	1995	$ 25,572	$ 541	$ 0	$ (541)		$ 25,572	42
43										43
44										44
45										45
46	TOTALS			$ 25,572	$ 541	$	$ (541)		$ 25,572	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,200,318	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 70,867	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 105,001	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 34,134	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,191,663	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Print Preview

(1) INCLUDES ALLOCATION OF HOME OFFICE ASSETS - SEE SCHEDULE.
(2) INCLUDES $4,149 OF ACCUMULATED DEPRECIATION FROM HOME OFFICE ASSETS - SEE SCHEDULE.
(3) FROM ALLOCATION OF HOME OFFICE ASSETS - SEE SCHEDULE.

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARRIER MILLS NURSING HOME LAND TRUST
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1968	42		$			3
4	Additions	1992	57	01/01/2000	220,800	1	AS AGREEI	4
5								5
6								6
7	TOTAL		99		$ 220,800 **			7

10. Effective dates of current rental agreement:
Beginning 01/01/2000
Ending 12/31/2000

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipm $ 4,238 Description: MISC. EQUIPMENT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

ent

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 95

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 60

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,250	$	$ 1,250
2	Books and Supplies		100		100
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,496		2,496
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		250		250
9	TOTALS	$	$ 4,096	$	$ 4,096
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,096			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	0
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	0
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,631	$ 94,631	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	430,743	430,743	3
4	Supply Inventory (priced COST)	1,618	1,618	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,000	25,000	6
7	Other Prepaid Expenses	13,177	13,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): A/R RELATED PARTY	10,000	10,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 575,169	$ 575,169	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		24,748	13
14	Buildings, at Historical Cost		1,439,296	14
15	Leasehold Improvements, at Historical Cost	47,212	47,212	15
16	Equipment, at Historical Cost	417,215	599,724	16
17	Accumulated Depreciation (book methods)	(404,525)	(1,088,306)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,000	1,000	22
23	Other(specify): UNAMORT. LOAN COSTS		11,196	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 60,902	$ 1,034,870	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 636,071	$ 1,610,039	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,618	$ 56,618	26
27	Officer's Accounts Payable	2,895	2,895	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,969	45,969	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,678	5,678	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,078	48,078	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED MANAGEMENT FEES	38,972	38,972	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 198,210	$ 198,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	237,577	1,548,653	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 237,577	$ 1,548,653	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 435,787	$ 1,746,863	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 200,284	$ (136,824)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 636,071	$ 1,610,039	48

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***(See instructions.)**

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Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (32,579)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (32,579)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,030	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(204,167)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 232,863	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 200,284	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,980,448	1
2	Discounts and Allowances for all Levels	(23,956)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,956,492	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	504	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 504	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 2,956,996	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 583,470	31
32	Health Care	1,023,568	32
33	General Administration	568,708	33
	B. Capital Expense		
34	Ownership	289,868	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,519,966	40
41	**Income before Income Taxes (line 30 minus line 40)****	437,030	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 437,030	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliatic SEE ATTACHED SCHEDULE**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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(1) ADJUSTED TO OFFSET COST ON PAGE 5, SECTION VI

Facility Name & ID Number CARRIER MILLS NURSING HOME # 0025130 Report Period Beginning 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 42,000	$ 20.19	1
2	Assistant Director of Nursing	1,960	2,080	32,000	15.38	2
3	Registered Nurses	11,767	12,859	172,316	13.40	3
4	Licensed Practical Nurses	19,401	21,636	200,781	9.28	4
5	Nurse Aides & Orderlies	42,722	45,226	299,393	6.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,960	2,080	32,025	15.40	7
8	Rehab/Therapy Aides	1,772	1,958	15,625	7.98	8
9	Activity Director	1,924	1,976	14,328	7.25	9
10	Activity Assistants	1,855	1,855	11,095	5.98	10
11	Social Service Workers	3,276	3,412	25,418	7.45	11
12	Dietician					12
13	Food Service Supervisor	2,360	2,435	16,899	6.94	13
14	Head Cook	5,000	5,352	32,431	6.06	14
15	Cook Helpers/Assistants	8,346	8,835	50,036	5.66	15
16	Dishwashers					16
17	Maintenance Workers	2,115	2,355	27,739	11.78	17
18	Housekeepers	24,372	25,491	139,438	5.47	18
19	Laundry	6,396	6,744	37,634	5.58	19
20	Administrator	904	983	18,000	18.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,190	6,444	56,865	8.82	24
25	Vocational Instruction	170	170	2,496	14.68	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,450	153,971	$ 1,226,519 *	$ 7.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	111	$ 3,838	1-3	35
36	Medical Director	PRN	3,300	9-3	36
37	Medical Records Consultant	44	1,305	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,114	10-a-3	39
40	Physical Therapy Consultant	195	9,653	10-a-3	40
41	Occupational Therapy Consulta	153	11,483	10-a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	82	5,943	10-a-3	43
44	Activity Consultant	24	1,080	11-3	44
45	Social Service Consultant	24	1,080	12-3	45
46	Other(specify)				46
47	PTA (CONTRACTED)	116	4,599	10-a-3	47
48					48
49	TOTAL (lines 35 - 48)	785	$ 43,395		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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